SUCCESSFUL AGING

# An Overview

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For a long time, developmental research in biology, medicine, and the social sciences was mostly directed to infancy and adolescence. With the aging of society, interest began to grow in the study of late adult life, a stage of life that is as forceful and full of changes and transitions as life before 20. We now know considerably more about aging than we did in the 1970s, when geriatrics became a recognized discipline and specialty in medicine.

Most of what we have learned about aging relates to so-called physiologic decline and the diseases of aging—that is, normal and abnormal aging. This knowledge of geriatrics has helped our patients. At the same time, many of our patients are asking for more. Frequently they ask their physicians, "What are the possibilities that I can *live*, not suffer, as I age?" Patients tell us: "It's sure no fun getting old." I used to respond by smugly saying: "It sure beats the alternative of not getting older—dying!"

Now I believe we need to be more sympathetic to our patients' message that it is "no fun getting old" and provide them with advice, skills, and treatments that help minimize age-related decline. Patients also want to reduce the risk of having age-related disease or to minimize the disability of these chronic diseases.

The growing number of old-old persons, and the basic human drive to stay well, accounts for the strong interest in successful aging.

This special issue of THE WESTERN JOURNAL OF MEDICINE is devoted to exploring various aspects of successful aging.

One of the chapters in a book entitled *Successful Aging* begins with the statement, "There is no consensus as to what the term successful aging means."[1] The volume includes contributions from social, biological, and medical scientists who describe successful aging as related to life satisfaction and development-related control beliefs. Others describe models and strategies for aging "successfully." Biomedical researchers address effects of successful or optimal aging on life expectancy and morbidity and distinguish successful from usual aging.[2]

Realizing that there may be no consensus about successful aging, we have organized this issue from what I believe is a patient's perspective. We begin by asking about the prospects for the prevention of acute and chronic diseases as we age. We know that the average life expectancy from age 65 is at least 19 years for women and 14 years for men.[3] The average life expectancy actually increases as persons survive to older ages. Thus, prevention and health promotion make sense at virtually any age.

In this issue, we also look at the major sources of age-related disability and morbidity from two perspectives. What is the nature of age-related decline and what are the prospects for modifying age-related decline? We also look at prevalent conditions associated with aging and ways that they limit optimal function or cause disability. Thus, we have asked authors to describe the possibilities to delay the onset of functionally limiting conditions or for minimizing excess disability associated with those conditions. In some instances, the answer may be, "There is not much that can be done" with, for example, macular degeneration per se. Nonetheless, there may be strategies for better adaptation or anticipating the inevitability of total blindness. Even though the content of the information may be discouraging to patients, most patients and their primary care physicians value the knowledge. In other instances—for example, living with osteoarthritis—patients and their primary care physicians may be pleasantly surprised by the opportunities to regain function.

The topics we have chosen are broad and include maintaining musculoskeletal and locomotor function, maximizing cardiovascular health, maintaining and restoring auditory and visual function, treating osteoarthritis, the use of medications, emotional health,

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maintaining cognitive function, and the importance of community resources in successful aging. We close with an article summarizing global interventions in a recent clinical trial designed to minimize the onset and effects of frailty.

Most patients want to maintain their well-being and minimize the effects of age-related decline. A few will ask us to help them achieve goals of high or elite performance into old age. Physicians need an information base to respond to these requests. Patients also seek advice on problems and disease—specific concerns related to aging. Most patients want to enhance function and maintain quality of life (or what social scientists call life satisfaction) in the context of a rising burden of age-related chronic diseases. Increasingly, physicians' jobs will be to manage and treat older patients seeking to live rich and productive lives in old age and with coexistent chronic disease.

Several themes are worth noting related to successful aging. Most will be interesting to our patients as well. First, longitudinal studies of changes in physical performance in older groups have shown patterns of both decline and improvement, thus suggesting that older age is not inevitably associated with decline.[4] Second, productivity can remain surprisingly high and may also improve with aging.[5] More than 90% of older adults do some productive activity. Catastrophic illness, especially stroke, can have a drastic effect on productivity. Psychosocial factors like life satisfaction and change in mastery also play an important role in productivity.

Another theme that appears repeatedly in the literature is the importance of moderate to strenuous exercise and the role of emotional support from social networks in predicting better physical performance.[6]

I am particularly impressed by the frequent disparity between disease severity and functional impairment that we see regularly in everyday clinical medicine. This phenomenon has been recently demonstrated in a study of the relationship of coronary artery disease severity and functional impairment that concluded that the relationship "is not as strong as may be assumed."[7] The study results suggest that at mild to moderate levels of disease severity and organ impairment, functional status is likely determined by a complex combination of biomedical and psychosocial factors, whereas in more severe disease, biomedical factors predominate. Modifiable psychosocial factors such as depression and anxiety, self-efficacy and quality of social support likely play an important role.

Physicians also play an important role in successful aging. We can be risk factors if we encourage too much bedrest and inactivity and thereby promote deconditioning. We are also (by definition) the cause of iatrogenesis, especially if we practice excessive polypharmacy and cause avoidable adverse drug reactions. This issue of THE WESTERN JOURNAL OF MEDICINE aims to help physicians become *protective* factors for successful aging in the way we practice (by avoiding iatrogenesis, of course) and the behaviors we promote, including encouraging conditioning and avoiding risk factors. Our older patients frequently see their physicians many times a year. They look to their physician for guidance. The role of the physician is crucial in achieving successful aging for many patients.

Even though there may be no generally accepted definition of successful aging, there is certainly much to be learned using successful aging as a heuristic for discussion. The knowledge base has considerable value for physicians and patients, although most researchers will characteristically note we still have "much yet to learn." As all readers are aging themselves, the value of learning about successful aging will serve the professional reader doubly—as a person and as a health care professional.

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